DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

Form 3-1

PERSONAL ASSISTANCE APPLICATION

1/00

Personal Data

Name:		Date of Birth:	
Address:	City:	State:	Zip:
Social Security #:	Home Phone:( )-	Work Phone:( )-	

Present living situation: ❒House ❒Apartment ❒Group home ❒Nursing home

❒Other (explain):

Description of Disabling Condition

Nature of disability:_____

Is this condition: ❒ Temporary or ❒ Permanent | Date of onset:

If temporary, please clarify as to duration: _____

Do you have a Medicaid Card? ❒Yes ❒No | What is your monthly income? $

Are you eighteen (18) years of age or older? ❒Yes ❒No

Do you require the assistance of another person to accomplish activities of daily living due to a functional loss of two (2) or more limbs? ❒Yes ❒No

Please check the number of hours of assistance you need each day

❒ 2-3 hours per day from a personal attendant to assist with **dressing, grooming, meal preparation, laundry, shopping, and eating**.

❒ 4-5 hours per day from a personal attendant to assist with **transferring, bathing/showering, range of motion exercises, transportation, food consumption, and assistance with bodily functions** in addition to dressing, grooming, meal preparation, laundry, shopping, and eating.

❒ more than 5 hours per day from a personal attendant to assist with **tasks requiring skilled or medically sensitive services such as respirator and catheter care, suctioning, or overnight attention** in addition to dressing, grooming, meal preparation, laundry, shopping, eating, transferring, bathing/showering, range of motion exercises, transportation, food consumption, and assistance with bodily functions.

Total number of hours per week of personal assistance requested: ____

How will your life change should you be accepted in this Personal Assistance Service Program? Please explain:_____

_____

_____

Person's Verification

I understand that due to fiscal limits my name may be placed on a waiting list. I understand that if I am found to be eligible only to receive state (non-Medicaid) funding, that my monthly benefit amount may be constrained. I also understand that if my needs change or I feel my circumstances warrant a higher priority on the waiting list that I may petition the personal assistance specialist. I verify that the information I have provided in this application is true and accurate. I agree to comply with all program requirements and I agree to use funds only to purchase personal assistance services.

Signature:	**Date:**

PERSONAL ASSISTANCE APPLICATION

1/00

Primary physician's name:_____ Phone:_____
Address:_____

Physician's Recommendation

Dear Physician: Your patient is applying for Personal Assistance Services through the Division of Services for People with Disabilities. Personal Assistance means: "Hands-on-care, of both an unskilled medical and non-medical supportive nature, specific to the needs of a medically stable, physically disabled individual." Please take a few minutes to complete this page. The information you provide will assist the Division staff in making a determination of whether your patient is eligible for service.

In order to qualify for personal assistance services an individual must:
(a) be capable of directing all aspects of his or her care, and
(b) due to a functional loss of 2 or more limbs require the assistance of another person to accomplish activities of daily living (e.g., dressing, grooming, meal preparation, laundry, shopping, eating, transferring, bathing/showering, range of motion exercises, transportation, food consumption, assistance with bodily functions**,** respirator, catheter care, suctioning, or overnight attention).

Name of patient:

Patient's diagnosis:

In my opinion the patient is capable of directing all aspects of his or her personal assistance services. ❒Yes ❒No If No, Please Explain:

Please indicate the extent of personal assistance you believe the patient requires:

❒ **none.**

❒ **2-3 hours per day.**

❒ **4-5 hours per day.**

❒ **more than 5 hours per day.**

Physician's Verification

I certify that due to the functional loss of 2 or more limbs the applicant requires assistance of another person to accomplish the activities described above as Personal Assistance Services. I also certify that the information I have provided on the application is true and correct to the best of my knowledge.

Physician's Signature:	**Date:**

Comments:

FOR DIVISION OFFICE STAFF ONLY
STAMP DATE RECEIVED IN BOX

Return Completed Form to:

Division of Services for People With Disabilities
attn: Personal Assistance Specialist
120 North 200 West Rm 411
Salt Lake City, Utah 84103